RHODE ISLAND RADIATION CONTROL AGENCY
APPLICATION FOR REGISTRATION
OF A DIAGNOSTIC X-RAY EQUIPMENT FACILITY

****FOR AGENCY USE ONLY****

Category ☐☐☐ Lic. No. ☐☐☐☐ Conditions _____

_____ / / _____ $ _____

Reviewed By **Date** **Amount Paid**

INSTRUCTIONS: Subpart B.3 of the *Rules and Regulations for the Control of Radiation [R23-1.3-RAD]* contains detailed instructions for completing this application. **Send the entire completed application to: RI Department of Health, Office of Facilities Regulation, Radiation Control Program, 3 Capitol Hill - Room 305, Providence, RI 02908-5097.** You should keep a copy of your completed application and attachments, as they will be incorporated into your registration by reference. Checks should be made payable to RI General Treasurer.

THIS IS AN APPLICATION FOR [*Check Appropriate Item*] ☐ NEW REGISTRATION

☐ AMENDMENT TO REGISTRATION #_____ ☐ CATEGORY CHANGE TO REGISTRATION_____

Facility Name: Please provide the name of the facility (as known to the public) for which you are applying for this license.	Name: _____
Facility Contact Person: Please provide the name and telephone number of a person we can contact concerning this facility.	Name: _____ Phone Number: (____) _____
Facility Mailing Information: Please provide the mailing information for all communication regarding this license. (**Not published on HEALTH website**).	Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ Address City, State, Zip Code _____ Address Country _____ Phone: _____ Fax: _____ Email Address: _____
Facility Location Information: Please provide the location information for this facility. (**Published on HEALTH website**).	Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ Address City, State, Zip Code _____ Address Country _____ Phone: _____ Fax: _____ Email Address: _____
Facility Supervisor Information:	Name: _____ Phone Number: _____ RI Medical/Dental License Number: _____ Specialty: _____ Medical/Dental Board Certification(s): _____ Date(s): _____
Individual Responsible for Radiation Protection:	Name: _____ Phone Number: _____ Title: _____

Consulting Radiation Protection Service [*If applicable*]:	Name: _____ RI Registration#: RPS _____
Ownership Type: Please check ONE	☐ Corporation ☐ Limited Liability Company ☐ Governmental Entity ☐ Partner ☐ Sole Proprietorship ☐ Partnership ☐ Limited Partnership
Ownership Information: Please provide ownership information for the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.	Name: _____ DBA: _____

THE CUSTOMARY AND USUAL RADIOGRAPHIC PROCEDURES PERFORMED AT THE FACILITY ARE:
[***Check ALL Applicable Items***]

☐ 0. None: equipment stored
☐ 1. Dental Intraoral
☐ 2. Dental Extraoral
☐ 3. Cephalometric
☐ 4. Chest and/or Extremities
☐ 5. Podiatric
☐ 6. Chiropractic
☐ 7. Veterinary
☐ 8. General Radiographic
☐ 9. Fluoroscopic
☐ 10. Mammographic
☐ 11. Contrast Media Studies
☐ 12. CT
☐ 13. Bone Densitometry
☐ 14. Specific Radiography (Specify)
_____
_____

DIAGNOSTIC X-RAY SYSTEMS INFORMATION: Provide the requested information for each diagnostic X-ray system at the facility.

Unit #*	Manufacturer	Model	# of Tubes	Location	Use**

*Unit # used to identify X-ray equipment should also be used to identify that same X-ray equipment in the shielding evaluation.

Use: Indicate the use of the equipment by inserting the number of the radiographic procedure listed. [*Continue on plain 8½" by 11" paper if necessary.***]

SHIELDING EVALUATION:
The type and scope of information to be provided is described in Appendix A to part B of the *Rules and Regulations for the Control of Radiation [R23-1.3-RAD]*.

FEIN Number: **(Federal Employer Identification Number)** **Note: If you are a sole proprietor this number may be your Social Security Number.**	**Pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended, any person applying for or renewing any license, permit, or other authority to conduct a business or occupation within Rhode Island must have filed all required state tax returns and paid all taxes due the state or must have entered into a written installment agreement to pay delinquent state taxes that is satisfactory to the Tax Administrator.** Please provide below FEIN/SSN for this license: F.E.I.N./SSN Number: _____

CERTIFICATION [*Must be completed by applicant*]:
The applicant and any official executing this certification on behalf of the applicant, certify that this application is prepared in conformity with the *Rhode Island Rules and Regulations for the Control of Radiation [R23-1.3-RAD]*, and that all information contained herein is correct to the best of their knowledge and belief.

_____ (Signature)
_____ (Type or Print Name of Certifying Official)
_____ Date
_____ Title:

FACILITY SUPERVISOR: _____ (Signature) _____ (Date)
[*If different from Certifying Official*]:

FORM RCA-R1 (December 2010) *Replaces Form RCA-R1(January 2006) Which Is Obsolete*